Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RGV HEALTHCARE SYSTEMS
P O BOX 6582
MCALLEN TX 78502

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-12-1238-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Paslak DC was required to perform range of motion for the examination and the carrier failed to reimburse the doctor for this service. We were also required to provide two reports due to a dispute regarding the extent of the compensable injury for the patient evaluated. Rule 130.6(b)(5) requires the designated doctor provide two reports when the extent of injury cannot be agreed upon by both parties. An additional Test was requested in order to complete the examination and answer the return to work question. The information from this test was incorporated into the final report which should also have been reimbursed $50.00 but was paid nothing. It is our position that the carrier provides no clear explination as for their rationale for denial and reduced payment. The charges were based on the DWC Medical Fee Guidelines and payment for these services are due with interest."

Amount in Dispute: $250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided designated doctor services 9/26/11 by determining maximum medical improvement (MMI) and impairment (IR) then billed Texas Mutual $650.00 for this with one unit of code 99456-W5-WP. Texas Mutual paid the requestor $350.00 for the MMI exam. The requestor used the lumbar spine DRE category to arrive at the IR…Texas Mutual paid the requestor $150.00 for this. Rule 134.202 at (j)(4)(C) states, 'For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (I) spine and pelvis; (II) upper extremities and hands; and, (III) lower extremities (including feet). (ii) The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.' The requestor billed code 99456-MI and was paid 99456-MI. The requestor billed code 99456-SP for referral of the claimant for nerve conduction testing to assist in determining impairment. It does not appear it was used or incorporated into the requestor's report. Thus, no payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 26, 2011	CPT Code 99456-W5-WP CPT Code 99456-MI CPT Code 99456-SP	$150.00 $50.00 $50.00	$0.00 $0.00 $0.00
TOTAL		$250.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. Texas Labor Code Title 5, Subtitle A, Chapter Subchapter A, in §408.0041 provides general provision for Designated Doctor Examinations and carrier responsibilities for payment of such services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 14, 2011
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - CAC-16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
   - 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS.

   Explanation of benefits dated December 5, 2011
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - CAC-193– ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824.
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
   - 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS.

Issues

1. Were the services in dispute appropriately billed?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor billed the amount of $650.00 for CPT code 99456-W5-WP with 1 (one) unit in Box 24G of the CMS-1500 for a Designated Doctor examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). The requestor also billed the amount of $50.00 for CPT code 99456-MI with 1 (one) unit in Box 24G of the CMS-1500 for multiple impairment ratings. Additionally, the requestor billed the amount of $50.00 CPT code 99456-SP for referral to testing for non-musculoskeletal body area(s) to a

specialist.

Per 28 Texas Administrative Code §134.204 states in part (j)(4))B)

(4) The following applies for billing and reimbursement of an IR evaluation.

(B) When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier 'MI' shall be added to the MMI evaluation CPT code.

Per 28 Texas Administrative Code §134.204 states in part (j)(4)(D)(iii)

(4) The following applies for billing and reimbursement of an IR evaluation.

(D) Non-musculoskeletal body areas shall be billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR.

(iii) When the examining doctor refers testing for non-musculoskeletal body areas(s) to a specialist, the following shall apply:

(I) The examining doctor (e.g., the referring doctor) shall bill using the appropriate MMI CPT code with modifier "SP" and indicate one unit in the units column of the billing form. Reimbursement shall be $50 for incorporating one or more specialists' report(s) information into the final assignment of IR. This reimbursement shall be allowed only once per examination.

2. Review of the submitted documentation in the DWC060 packet, the Division finds no narrative reports, medical records, DWC required forms or any other form of medical documentation submitted for review to support the disputed services. Therefore, the disputed services are not reimbursable as they are not properly documented.
3. The respondent has previously reimbursed the amount of $500.00. Therefore, the requestor is not entitled to additional reimbursement for undocumented services.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

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Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 7, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.